Toward integrated medical resource policies for Canada: 1. Background, process and perceived problems

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Issues of the supply, mix, distribution, regulation, remuneration and training of physicians have permeated discussions of Canadian health care policy for at least three decades. They spawned many national and provincial task forces and research reports from the 1970s through the mid-1980s and have, we suspect, motivated the recent epidemic of provincial royal commissions. But policy development has not kept pace with the frequency of the reviews or the calls for change; in fact, despite a lot of sound and fury, remarkably little has substantively changed since 1971.

What is different now, perhaps, is the sense of urgency that things must change — in many cases dramatically — very soon. This urgency prompted the Federal/Provincial/Territorial Conference of Deputy Ministers of Health (CDMH) in late 1989 to seek a review of the potential for regional and national approaches to physician resource policy in Canada. The commonality of problems and the apparent impotence of individual jurisdictions to address many of them effectively resulted in a request for "a national (and, in some cases, regional) strategy and action plan . . . to successfully address problems which provinces or regions cannot manage on their own" (Jody Jones: personal communication, 1990).

In the late spring of 1990 we were commissioned by the CDMH to prepare a strategy discussion paper based on an analysis of national, regional and provincial options for addressing the physician resource management problems faced by all jurisdictions. This work was completed during the following year, and a report was released by the CDMH in the summer of 1991.[1] The document summarizes the project and outlines the recommendations and policy options arising from our research. The complete background materials reporting the detailed results of our interviews and analyses are contained in two lengthier reports.[2,3]

In this Medical Resources series we will attempt to provide a "middle ground" — a reporting of the analyses underlying our recommendations and options that is more complete than could be accommodated in the summary report[1] but that is shorter than the background documents.[2,3] However, the fundamental complexity of the problems, and thus of any effective solutions, means that something is inevitably lost in the process of summary. Readers interested in our detailed analysis of any policy area are encouraged to consult the comprehensive report.[2]

We intend whenever possible to achieve this middle ground by extracting information from that more detailed report. Thus, this series will represent a distillation, not an update, of the full report presented to the CDMH in May 1991. Our interest is in promoting more widespread consideration and

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discussion of the analyses, options and recommendations, particularly among clinicians and educators who might otherwise be unfamiliar with the report.

In this first paper we will describe the objectives and procedural aspects of the project, report some of the results from our interviews and outline briefly the content of the remaining papers in the series. Our interviews were held to elicit the views of a broad sample of stakeholders on key problems and possible solutions. We will report on the former here.

Objectives

We felt that a comprehensive attempt to quantify the supply, mix, requirements and distribution of physicians would cost far more and take far longer than anything the CDMH had contemplated. In addition, it would not necessarily enlighten the policy debates further. Therefore, our starting point was the observation that the perception of a set of common problems had motivated the study, and our first objective was to ascertain (a) whether there was general agreement on key problems and issues and (b) the extent of agreement on the main problems identified by the CDMH.

We were also interested in the extent to which regions or provinces were beset by problems that were not widespread, "Canadian" problems, because such situations would present challenges and constraints for any national strategy. Thus, our second objective was to develop as complete a picture as possible of current issues related to physician resources.

Our third objective was to elicit the views of those who earn their living working in the Canadian health care system — planners, policy-makers, regulators, clinicians, administrators, educators and researchers — on the root causes of the problems and on possible solutions. Here, our particular interest was the possibility for collaborative solutions that cut across either regional boundaries or broad stakeholder constituencies.

The fourth and most daunting objective was to develop solutions and innovative policy avenues, particularly opportunities for collaboration between provinces and territories and between stakeholders. We hoped to develop general directions, mechanisms and a list of participants for what we believed to be the most pressing current issues in physician resource management in Canada. We were conditioned by the knowledge that most issues were not new and many solutions had already been proposed, yet most of the problems remained and were getting worse. New approaches, alliances and attitudes would clearly be necessary. Solutions would need to be more creative, more sensitive and more integrated than their predecessors.

Process

The project comprised somewhat overlapping phases of information gathering, analysis and report writing.

Information gathering

We gathered information from interviews and consultations, a commissioned report on policy experience in Quebec, commissioned reports on experiences abroad, and a review of the scientific literature and of "trade" newspapers and journals. Interviewees were selected to ensure that (a) at least one interviewee (preferably more) would represent each province and territory and the federal government, (b) at least one interviewee (preferably more) would represent each of the key stakeholder groups or policy areas and (c) travel time and costs would be minimized by creating geographic interview clusters.

Six different combinations of interviewers conducted over 70 interviews. Because of the sample, the nature of the topics and the structure of the interviews, potential methodologic problems associated with multiple interviewers were not a major concern. We deliberately oversampled some of the stakeholder groups.

In addition to the deputy ministers of health (or designated senior staff) we interviewed representatives of the medical profession, faculties of medicine responsible for undergraduate and postgraduate medical education, licensing authorities, medical examining bodies, affiliated teaching hospitals, and recently formed task forces and royal commissions. We also consulted with a variety of policy analysts. The complete list of interviewees can be found in the published reports.[1,3]

An interview format was provided before the meetings. It contained a list of problem areas identified by the CDMH, some potential underlying causes and some broad guidelines about the types of solutions we were most interested in exploring. Interviewees were invited to comment on the problems and causes, identify other problems and provide relevant insights. However, our overriding principle was that the interviews be flexible and candid and that those interviewed be constructive participants in the project. Furthermore, we attempted to work to each interviewee's advantage by focusing on problems and possible solutions related to his or her area of expertise.

The commissioned study on policy experience in Quebec was intended to provide a detailed understanding of that province's policy history: the prob-

lems, effects and potential generalizability across Canada of some of its more unique initiatives. We also commissioned short reports from Australia, Belgium, Britain, France, Germany, New Zealand and Sweden. The international reports and the one on Quebec are included in their entirety in the background documents.[3]

The fourth activity in gathering information was a comprehensive review of the scientific literature, the *Medical Post*, recent reports of councils, task forces and provincial royal commissions, and other reports and materials provided by interviewees and colleagues.

Analysis

We undertook no new analyses of the supply, mix or distribution of physicians. We produced minutes of each interview in considerable detail and then analysed them all to determine problem areas, causes and potential solutions. Inventories were created to identify in which areas there seemed to be agreement on problems or directions for change or on suggestions for facilitating change. Position statements and evidence from the literature were synthesized with the results of the interviews.

Thus, our report emerged from a systematic, extensive and intensive process of review, synthesis and "brainstorming." We drew on the interview material, research and other literature, and our interpretation of that "evidence" in terms of what might be possible.

Views from the field — problems

General reflections on the interview process

The interviewees were extremely forthright in general, they attempted to be constructive, and they seemed to believe that the task, although daunting, was worth while and timely.

Virtually all suggested that there was cause for concern, although they disagreed on the extent to which specific problems were, in fact, problems. We were told repeatedly that some aspects of the current situation were simply untenable and that many factors were responsible for the current situation — past inaction, stakeholder intransigence, lack of political will, failure to adjust to changing information and requirements, inappropriate and ill-informed expectations, and a lack of purpose and direction for Canadian health care.

Interviewees were remarkably introspective. Some deans of medicine suggested that academic medical centres had been remiss in fulfilling their responsibilities to the Canadian public, that the medical education establishment was training too many physicians in order to protect its financial base and that the manner of funding Canadian medical schools was encouraging the abuse of fee-for-service medicine in Canada. Some senior ministry of health officials told us that the ministries and ministers of health had been woefully negligent in their roles as agents for the public and had failed to muster the political will necessary to take difficult but essential steps in forming medical care policy. Representatives of the medical profession acknowledged that governments had a public responsibility to ensure fiscal control over health care costs, and some licensing representatives felt they should be doing much more in the way of quality assurance. Not surprisingly, this self-flagellation was accompanied by the tendency for interviewees to identify as key problems many areas that were the responsibility of other parties.

Although very many problems were identified there was little consensus on their relative importance. Many problems were mentioned by at most a handful of interviewees. Nevertheless, our synthesis of the interview materials revealed two classes of problems: (a) "first-tier" problems (key problems that were mentioned most often) and (b) "second-tier" problems (those that were mentioned less frequently or that were considered to be somewhat less serious).

First-tier problems

Graduates of foreign medical schools: All of the stakeholder groups interviewed cited as a key problem the large numbers of graduates of foreign medical schools entering practice in Canada through various channels of "control." Although this seems to be simple enough, the mechanisms and responsibility centres are complex and diverse. This source of supply was argued to be a problem because (a) foreign medical graduates make it politically difficult to reduce the number of domestic medical school and postgraduate training positions, (b) some foreign graduates provide poorer-quality medical care than Canadian graduates, (c) individual provincial licensing arrangements and entry routes create subsequent pressures for postgraduate training slots, (d) problems with Canadian curricula and the mix of residency training positions create avoidable demands for foreign graduates, (e) foreign graduates who enter into restricted geographic positions or enter into practice through special licensure arrangements are neither held to those commitments nor compelled to return to their country of origin after completion of their term, (f) further reductions in the capacity of Canadian medical schools would drive more students to the United States, where the ratio of applicants to entrants has

fallen dramatically over the past decade (this would create a large pool of "Canadian" foreign graduates), and (g) foreign graduates represent a source of increased physician supply over which provincial ministries of health have insufficient control, yet ministries are then saddled with the (assumed) increased medical and health care costs.

Mix and number of residency training positions: The mix of residency training positions bears no relation to what would emerge from a "zero-base" effort to best meet the current and future needs of Canadians. This problem was presented as historical precedent perpetuated by academic intransigence and lack of political interest or will. Although the number of positions has been dominated by funding from provincial ministries of health the proportion funded from other sources has been increasing. The total number of postgraduate training positions in Canada is at present under no one's control, and the channels through which residents in non-ministry-funded positions gain specialty certification and provincial licensure are not well understood. The current position mix is the product of a dynamic and ongoing competition among residency training program directors and clinical department heads. The rules of the competition appear to preclude the relinquishing of any "ground" gained; the training "needs" of other specialties must be met through the search for even more collective ground and not through the reallocation of positions already secured.

The number of residency training positions reflects in part responses to student demand. Students tend to choose subspecialties as ways of bounding a rapidly expanding base of clinical knowledge. In addition, many subspecialties are perceived to have greater prestige, status and glamour than many of the generalist specialties, and inequities in provincial fee schedules tilt choices toward procedure-based subspecialties.

Role and funding of academic medical centres: These centres have largely failed to articulate clear and coherent missions and objectives and to design policies to meet them. There is little public recognition of the multiple roles they attempt to play. The narrow public view of academic medical centres as training sites for future physicians has reinforced the viewpoint that centres are trade schools that have no fundamental place in the university. This, in turn, has seriously affected the sources and stability of funding for those faculties and their affiliated teaching hospitals.

The problem most often noted for medical faculties was their growing dependence for financial survival on the clinical, fee-for-service earnings of their geographic full-time and affiliated clinical faculty. The importance of clinical-service earnings influences educational and research priorities of the faculty. As a result the case for funding from ministries of higher education, which fund teaching and research faculty and infrastructure but not clinical service, is undermined and the importance of clinical earnings increased. Furthermore, any broader physician resource policies that would reduce the number of postgraduate training positions would tend to undermine the financial base of the academic enterprises, because these enterprises depend so heavily on clinical earnings for services rendered at least in part by their residents. Finally, a considerable amount of undergraduate teaching and intern and resident supervision is provided by clinical faculty members who receive no or little direct remuneration for that educational service.

Poor geographic distribution of physicians: Specific problems identified included shortages in rural areas of family physicians and many types of specialists, including general surgeons, general internists, obstetrician-gynecologists, anesthesiologists, cardiologists and psychiatrists. Overall, the rural shortages of general or family practitioners were considered to be less serious than the restricted access to a variety of specialist care. The overwhelming consensus was that there were serious surpluses of general practitioners in urban centres.

Fee-for-service remuneration: The dominance of fee-for-service remuneration in Canada was identified as a major problem by a broad cross-section of the interviewees. One of the interviewees suggested that it was the biggest problem — that the issues of physician supply, foreign medical graduates and funding of academic medical centres, for example, all reduce to issues of fee-for-service remuneration.

This type of remuneration was thought to be a problem for two reasons: it encourages the proliferation of procedures and visits, and fee-schedule inequities have far-reaching implications for other areas of physician resource management. Some of those interviewed also highlighted the problems that such remuneration poses for hospitals. It is fundamentally inconsistent with the way in which hospital funding has evolved in Canada, and government pressure on fees has generated increasing demands from clinical staff to be remunerated (from global hospital budgets) for administrative work.

Second-tier problems

Undergraduate medical school curricula and postgraduate training exposure: The predominant view was that the curricula and the educational process in Canada were rigid and not willingly adapted to the realities of medical care for the 1990s. They were, therefore, the root of some of the other problem

areas. As one particularly cynical observer (who had successfully survived the ordeal of medical school) put it, "[Medical school] is the most severe socialization process outside of the US marine corps," and this socialization process creates graduates who are unable to distinguish the content from the context of medical practice.

We heard allegations of an overemphasis on hospital-based teaching and little content or exposure that would encourage or promote practice in rural areas, insufficient emphasis on evidence-based medicine, little effort to train primary care physicians for the "gatekeeper" role and insufficient curricular emphasis on health care system issues, effectiveness and efficiency.

Proliferation of subspecialties and residency training programs: The tendency toward subspecialization in medicine creates pressures to increase the number of distinct residency training programs in Canadian medical schools. Provincial ministries of health fund most training positions in Canada, yet they have no control over the proliferation of these positions. In addition, new subspecialty certification rapidly becomes a requirement for "entry to practise within an area of specialization." This in turn creates pressure for more training opportunities in the subspecialty. Procedure-rich tertiary specialties were singled out as being particularly susceptible to proliferation.

Licensure and self-regulation: Of greatest concern was the issue of common interprovincial prelicensure standards. Fears were expressed that licensing requirements of each province or territory not only restrict the mobility of Canada's physicians but also undermine attempts to make Canada's medical schools a "national" resource.

Three other issues were mentioned less frequently. There was considerable disagreement on the role of exclusive fields of practice: some of the interviewees argued that such practice impedes the more efficient provision of significant segments of care, whereas others felt that it is necessary to ensure that only suitably qualified people perform medical acts. The opposing views on this came from the expected stakeholders. A second issue was the role of provincial colleges in quality assurance, the promulgation and application of clinical practice guidelines, and other forms of monitoring of the quality and necessity of medical care provided to the public. There were concerns that the colleges have failed to interpret their mandate from a sufficiently broad perspective and that this indicates a need to re-examine their self-regulatory role.

Future articles

These priority problems were the views of practitioners, administrators, educators and policy-makers from across Canada. The interviews represented one source of information on which we based our analyses. In subsequent articles we will focus on particular themes or policy issues, presenting our analyses and the conclusions, options and recommendations arising from them. In the Mar. 1 and Apr. 1, 1992, articles we will describe some key overarching themes and the general framework that guided our analytic approach and helped us to ensure that all recommendations were consistent.

We thank the many people who candidly shared their concerns and their ideas for solutions with us during our extensive interviews.

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